



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Medi-Plus Pharmacy

Respondent Name

American Insurance Company

MFDR Tracking Number

M4-13-0063-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medi-Plus Pharmacy, an independent pharmacy has been providing medications in accordance to 134.503."

Amount in Dispute: \$109.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have paid the recommended allowance per Red Book with the AWP 3.36678 for brand name prescription."

Response Submitted by: Fireman's Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2012 – May 16, 2012	Lyrica 50 mg capsules	\$109.08	\$109.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - W1 – Workers' Compensation State Fee Schedule Adjustment.
 - Note – Charge for this procedure exceeds average wholesale price plus mark-up.

- Note – We are unable to recommend an additional allowance since this claim was paid in accordance with the state’s fee schedule guidelines, First Health Bill Review’s usual and customary policies, and/or was reviewed in accordance with the provider’s contract with First Health.

Issues

1. Does a network issue exist for this dispute?
2. How is reimbursement established for the disputed services?
3. Did the requestor support the request for additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim stating,

We are unable to recommend an additional allowance since this claim was paid in accordance with the state’s fee schedule guidelines, First Health Bill Review’s usual and customary policies, and/or was reviewed in accordance with the provider’s contract with First Health.

Texas Insurance Code §1305.101(c) states,

Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, **may not, directly or through a contract, be delivered through a workers' compensation health care network** [emphasis added]. Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation.

Review of the submitted documentation indicates that this dispute is related to prescription medication. Documentation was not found to support that the claim is part of a certified network. Regardless of the claim’s network status, the treatment included in this dispute may not be delivered through a health care network and is subject to the fee guidelines found in 28 Texas Administrative Code §134.503.

2. 28 Texas Administrative Code §134.503(c) states:

- (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
 - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data **in effect on the day the prescription drug is dispensed** [emphasis added]:
 - (A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;
 - (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
 - (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider; or
 - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

Reimbursement for the date of service in question is the lesser of the fee established by the applicable AWP formula, or the billed amount pursuant to 28 Texas Administrative Code §134.503(c).

3. The pharmaceuticals in dispute were dispensed from February 22, 2012 through May 16, 2012. The medication in dispute is Lyrica 50 mg capsules, NDC 00071101368. Review of the submitted documentation finds:

- that the requestor provided documentation sourced from First Data Bank that supports the AWP rate of 3.3668 for Lyrica 50 mg capsules, NDC 00071101368, effective for dates February 22, 2012 through May 16, 2012; and,
- the insurance carrier asserts that it “paid the recommended allowance per Red Book with the AWP 3.36678 for brand name prescription.”

The division finds that the requestor supported that the AWP rate of 3.3668 was effective for the dates of service in question. Therefore, reimbursement is calculated below:

Date Dispensed	Prescription Medication	Calculation per 134.503(c)(3)(A)	134.503 (c)(3)(B)	Lesser of 134.503 (c)(3)(A) & (B)	Carrier Paid	Balance Due
2/22/12	Lyrica 50 mg capsules	$(3.3668 \times 90 \times 1.09) + \$4.00 = \$334.28$	\$334.28	\$334.28	\$307.01	\$27.27
3/21/12	Lyrica 50 mg capsules	$(3.3668 \times 90 \times 1.09) + \$4.00 = \$334.28$	\$334.28	\$334.28	\$307.01	\$27.27
4/18/12	Lyrica 50 mg capsules	$(3.3668 \times 90 \times 1.09) + \$4.00 = \$334.28$	\$334.28	\$334.28	\$307.01	\$27.27
5/16/12	Lyrica 50 mg capsules	$(3.3668 \times 90 \times 1.09) + \$4.00 = \$334.28$	\$334.28	\$334.28	\$307.01	\$27.27

The total reimbursement amount for the disputed services is \$1337.12. The insurance carrier paid \$1228.04. An additional reimbursement of \$109.08 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$109.08.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$109.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"></div> <div style="width: 40%; text-align: right;"> Laurie Garnes </div> </div>	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"></div> <div style="width: 40%; text-align: right;"> August 29, 2016 </div> </div>	
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.